

**INDIVIDUAL CRISIS COUNSELING SERVICES
ENCOUNTER LOG**

PROVIDER NAME _____ **PROVIDER #** _____

EMPLOYEE # _____ **DATE OF SERVICE** / / **ZIP CODE OF SERVICE**
(MM/ DD/ YY)

LOCATION OF SERVICE (SELECT ONE)

school workplace place of worship
community center disaster recovery center individual's home
provider site other _____

TYPE OF VISIT 1st visit 2nd visit 3rd visit 4th visit 5th visit or more

DURATION 15-29 minutes 30-44 minutes 45-59 minutes 60 minutes or more

RISK CATEGORIES (SELECT ALL THAT APPLY)

injured or physically harmed	home had damage	evacuated quickly with no time to prepare
life was threatened	displaced from home 1 week or more	witnessed community destruction
family missing/dead	disaster unemployed	past substance use/mental health problem
friend missing/dead	other financial loss	pre-existing physical disability
witnessed death/injury	assisted w/ rescue/recovery	past trauma
prolonged separation from family		

DEMOGRAPHIC INFORMATION

AGE (select one) preschool (0-5) childhood (6-11) adolescent (12-17) adult (18-39) adult (40-64) adult (65+)	ETHNICITY (select one) Hispanic or Latino Not Hispanic or Latino	PREFERRED LANGUAGE (select one) English other _____
SEX (select one) male female	RACE (select one or more) American Indian / Alaska Native Asian Black or African American Native Hawaiian / Pacific Islander White	LANGUAGE OF CONTACT (select one) English other _____
		PARENT/GUARDIAN OF CHILD < 18 (select one) no yes unknown

REFERRAL (SELECT ALL THAT WERE COMMUNICATED)

other crisis counseling services	mental health treatment
other disaster services (e.g., FEMA loans, housing)	substance abuse treatment
other services _____	none

WAS THE REFERRAL ACCEPTED BY THE INDIVIDUAL? no yes

REVIEWED BY (PRINT) _____ SIGNATURE _____ DATE ____/____/____

INSTRUCTIONS:
INDIVIDUAL CRISIS COUNSELING SERVICES ENCOUNTER LOG FORM

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 2 minutes per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

When to Use This Form:

Complete this form immediately **after** the individual crisis counseling service is provided.

1. Complete this form for each individual who receives individual crisis counseling services.
2. An individual crisis counseling encounter is defined as a contact where the discussion goes beyond education and assists the person to understand their current situation and reactions, review their options, and address their emotional support or referral needs.
3. This form is also to be used for **families**. Complete a single form for each member of the family that participates in/receives crisis counseling. For example, a husband and wife along with their two children attend an individual crisis counseling session. The husband and wife actively participate with the crisis counselor, but the children sit quietly. You must complete one form for the husband and a separate form for the wife.
4. This form is not intended to be used as a survey. Do not ask the individual for any of the information on this form. Complete all items on the form based on your best observations and information you received during the encounter.

PROVIDER NAME – The name of the program/agency.

PROVIDER # - The unique number your program/agency is providing services under.

EMPLOYEE # - YOUR employee number.

DATE OF SERVICE – The date of the encounter.

ZIP CODE OF SERVICE – The zip code of the location you had the encounter in.

LOCATION OF SERVICE – Where did you provide the service? **SELECT ONLY ONE.**

TYPE OF VISIT – Based on your conversation with the individual, is this the 1st, 2nd, 3rd, 4th, 5th or more visit for this person to your program? All visits did not have to be with you. **SELECT ONLY ONE.**

DURATION – How long did your encounter last? **SELECT ONLY ONE**

RISK CATEGORIES – These are factors that an individual may have experienced or may have present in their life that could increase their need for services. **MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.**

DEMOGRAPHIC INFORMATION - For each variable, **SELECT ONLY ONE**

AGE – The age you perceived the person to be. **SELECT ONLY ONE**

SEX – Was the person male or female? **SELECT ONLY ONE**

ETHNICITY – Based on your observations and your conversation with the individual, what ethnicity do you think the individual was? **SELECT ONLY ONE.**

RACE - Based on your observations and your conversation with the individual, what race do you think the individual was? **SELECT ALL THAT APPLY.**

PARENT/GUARDIAN OF CHILD - Based on your observations and your conversation with the individual, is the individual the parent or guardian of a child under 18 years of age? **SELECT ONLY ONE.**

PREFERRED LANGUAGE – What language did the individual prefer to talk to you in? If "OTHER", fill in the other language (not English) that the person preferred to speak in. **SELECT ONLY ONE.**

LANGUAGE OF CONTACT – What language did you actually use to speak with this individual during the encounter? This may be different than the preferred language. If "OTHER", fill in the other language (not English) that the person spoke in. **SELECT ONLY ONE.**

REFERRALS – Based on your conversation with this individual, you may have referred the individual for other services. In the REFERRAL box, select all of the types of services you referred the person to. If the service is not listed, please provide the type of service next to "OTHER SERVICES." If you did not make a referral, please select "NONE."

WAS THE REFERRAL ACCEPTED BY THE INDIVIDUAL? Based on your conversation with the individual, indicate whether or not the person accepted the referral information.

STOP! Please submit the completed form to the designated person in your agency who will review and sign the form. ***Thanks for taking the time to complete this form accurately and correctly!***